STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555442	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Post Acute	6821 24th Street Sacramento, CA 95822

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47197 Based on observation, interview, and record review, the facility failed to maintain resident's right to privacy and confidentiality of personal and medical records for one resident out of a census of 112 residents when a computer screen that showed a resident's photo and confidential personal and medical information was left unsecured and unattended. These failures had the potential to result in unauthorized access of residents' personal and medical information. Findings: During an observation on 11/4/24 at 1:50 p.m. near nurse's station 1, 2, & 3, next to the facility lobby, a computer on top of a treatment cart had a screen showing a resident's photo, complete name, medical record number, current room and bed number, gender, date of birth, age, attending physician, and other pertinent personal and medical information. It was left unattended facing the facility lobby. Four residents and three facility staff were observed passing by the treatment cart. Multiple staff were in the facility lobby. During a concurrent observation and interview on 11/4/24 at 1:50 p.m. near nurse's station 1, 2, & 3, next to the facility lobby, Physical Therapy Assistant (PTA) 1 confirmed the observation of a computer on top of a treatment cart with screen showing a resident's photo and pertinent personal and medical information left unattended and was facing the facility lobby. PTA 1 stated the computer should have been closed or covered because it has resident's confidential personal and medical records. During an interview on 11/6/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated the staff should protect residents' records. The DON further started, .It's [leaving resident's personal and medical records unattended] HIPAA (Health Insurance Portability and Accountability Act- a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed) violation . A review of the facility's policy and procedure (P&P) titled, Confidentiality of Personal and Medical Records, dated 7/1/23, indicated, This facility honors the resident's right to secure confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Resident Rights, dated 6/1/24, indicated, 7. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34980 Based on observation, interview, and record review, the facility failed to maintain a safe, comfortable, and homelike environment for one of 25 sampled residents (Resident 70) when a hole was observed in the wall of Resident 70's room. This failure created a non-homelike environment for Resident 70. Findings: Resident 70 was admitted to the facility in 2024 with diagnoses that included a stroke (damage to the brain from an interruption of its blood supply), hemiplegia (the inability to move one side of the body), and aphasia (a condition affecting the ability to express language). A review of Resident 70's Minimum Data Set (MDS - an assessment tool used to guide care) Cognitive (having full understanding) Patterns, dated 9/27/24, indicated Resident 70 had a Brief Interview for Mental Status (a tool to assess a persons' full understanding) score of 14 out of 15 which indicated Resident 70 was cognitively intact. During an observation on 11/4/24 at 10:17 a.m., Resident 70's room had a six inch by 12 inch hole in the drywall with exposed plumbing approximately two feet above the floor below the television. During an interview with Resident 70 on 11/4/24 at 10:17 a.m., Resident 70 pointed to the hole in the drywall and when asked if the hole bothered him, Resident 70 nodded his head indicating yes. During a concurrent observation and interview with the Administrator (ADM) on 11/6/24 at 10:12 a.m., the ADM verified the six inch by 12 inch hole in the wall. The ADM stated the sink was removed and the wall had not been patched. The ADM further stated, There should not be a hole in the wall, and it should have been fixed. A review of the facility policy titled, Safe and Homelike Environment dated 6/1/23 indicated, In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based on staff interview, record review and policy review, the facility failed to ensure an assessment accurately reflected the resident's status for one of 25 sampled residents (Resident 112). This deficient practice had the potential for inaccurate care. Findings: Resident 112 was admitted to the facility on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the digestive system and chronic obstructive pulmonary disease (COPD-lung disease). Review of Resident 112's MDS (Minimum Data Set-an assessment tool), dated 9/7/24 under section A0310 Type of Assessment-Continued indicated unplanned discharge. Under section A2105 Discharge Status indicated Resident 112 went to 04. Short-Term General Hospital (acute hospital .). During a review of Resident 112's Progress Note dated 9/7/24 at 10:54 a.m., indicated Res (resident) decided that he wanted to go home against medical advice (AMA) today. Risk and benefits explained to the res but still doesn't want to stay and verbalized i (sic) rather be home. MD (Medical Doctor), DON (Director of Nursing) and administrator was tonified (sic). Res signed the AMA release form; he was picked up by his roommate at 0955am (9:55 a.m.) During a review of Resident 1's medical record contained a form tilted AMA Release Form, dated 9/7/24 at 9:40 a.m. indicated Resident 1 was discharging against medical advice. During an interview on 11/06/24 at 9:17 a.m. with the MDS Coordinator Assistant (MDSCA), she confirmed Resident 112 went home AMA on 9/7/24. The MDSCA confirmed Resident 112's MDS dated [DATE] under section A2105 Discharge Status was the wrong code. The MDSCA further confirmed the MDS should have been coded 01 (Home/Community). Review of the facility policy and procedure (P&P) titled Conducting an Accurate Resident assessment dated [DATE] indicated, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. The P&P indicated, ''Accuracy of assessment'' means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47197 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one out of 25 sampled residents (Resident 105) when Resident 105's respiratory care and nebulizer (machine that turns liquid medicine into a mist that can be easily inhaled) treatment care plan was not developed. This failure placed Resident 105 at risk to not meet his medical needs and to not achieve the highest practicable well-being. Findings: A review of Resident 105's clinical record indicated Resident 105 was admitted October of 2024 and had diagnoses that included parkinsonism (a clinical syndrome characterized by tremor, slowed movement, rigidity, and postural instability), asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe), dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 105's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 10/18/24, indicated Resident 105 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 105 had a moderately impaired cognition. A review of Resident 105's MDS Health Conditions, dated 10/18/24, indicated Resident 105 had experienced shortness of breath or trouble breathing when lying flat. A review of Resident 105's physician's order, dated 10/16/24, indicated, Ipratropium-Albuterol Solution [a liquid medicine used to prevent and treat symptoms caused by lung diseases which is administered via nebulizer] . 1 vial (a glass container used for holding liquid medicines) inhale orally via nebulizer four times a day for Asthma WAIT 5 MINUTES BEFORE GIVING ANOTHER INHALER/NEBULIZER SOLUTION. During a concurrent interview and record review on 11/6/24 at 9:57 a.m. with Licensed Nurse (LN) 4, Resident 105's active care plan was reviewed. LN 4 confirmed that Resident 105 had no respiratory care and nebulizer treatment care plan developed. LN 4 stated she knew Resident 105 used a nebulizer and she expected that it should be in Resident 105's care plan. LN 4 further stated, It [respiratory care and nebulizer treatment] should be in the care plan .It's [respiratory care and nebulizer treatment care plan] not there [list of active care plan] .It's [care plan] the plan for the resident .So we [facility staff] will know what care we need to provide to him [Resident 105]. During an interview on 11/6/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated she would expect that respiratory care and nebulizer treatment will be part of the care plan for Resident 105. The DON further stated that care plan is for nurses' guidance on providing care to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled, Care Plan Revisions Upon Status Change, dated 6/1/24, indicated, 1. The comprehensive care plan will describe the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .f. Resident-specific interventions that reflect the resident's needs and preferences .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40903 Based on observation, interview, and record review the facility failed to ensure safe Quality Control (or QC, proactive testing and calibration for accuracy of devices) and resident care practices with resident census of 112 based on standards of practice and facility's policy when: 1. The facility did not perform Quality Control (testing and calibration for accuracy) for glucometer (a machine that measures the blood sugar level) devices consistently based on facility's policy and the manufacturer recommendations. 2. Nursing care did not follow orders for checking feeding tube (surgically inserted tube into the stomach for feeding or medication administration when oral route not available) residuals (practice of checking volume of residue in the tube connected to stomach; this helped with reduced risk of aspiration [when stomach contents get into lung]) and keeping head elevated when medication was given to Resident 82 via feeding tube. These failed practices could contribute to unsafe care of diabetes resident with blood sugar monitoring and risk of complications from tube feeding. Findings: 1. During a concurrent interview and record review of facility's document, titled Quality Control Record, with date range of June 2024 to November of 2024, accompanied by Licensed Nurse 9 (LN 9), on 11/5/24, at 9:51 AM, at back nursing station, the QC records for facility's glucometer devices were not consistently performed. LN 9 stated the QC checks were done by night shift staff for all glucometers in the medication carts. LN 9 acknowledged the following inconsistent testing and/or documentation: The review of glucometer QC record for medication cart #4 did not have complete documentation from 6/21/24 to 6/30/24. LN 9 could not locate QC record for the month of July and August of 2024. The QC record for 9/2024 was missing input from 9/21/24 to 9/30/24. The QC record for 10/2024 was missing input from 10/11/24 to 10/16/24. The QC record for first week of 11/2024 was missing input from 11/1/24 to 11/4/24. In an interview with the Director of Nursing (DON), in her office, on 11/5/24, at 3:35 p.m., the DON stated the night shift staff were responsible to do QC check of glucometers and the Director of Staff Development (or DSD, a role responsible for initial and ongoing staff education and onboarding) and DON were responsible to check if QC were documented. DON stated the glucometer QC check assured the accuracy of blood sugar measurements. Review of the facility's policy, titled Blood Glucose Monitoring, dated 1/1/23, the policy indicated Calibration checks on glucometer must be performed as per the manufacturer's instruction. Review of the facility's glucometer manufacturer, brand name EVENCARE G3, dated 2016, the document indicated The purpose of the control solution testing is to validate that the EVENCARE G3 Meter is working properly with the test strips . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication administration observation of Resident 82, with Licensed Nurse 6 (LN 6), on 11/4/24, at 4:27 p.m., LN 6 prepared a new feeding bag (nutritional fluid) for use at a later time, then crushed a medication called glycopyrrolate (Drug used to reduce secretions in the mouth) to administer to Resident 82 through the feeding tube (a surgically inserted tube into the stomach.) LN 6 entered the room with Resident 82 lying down on her left side, accessed the feeding tube, flushed the feeding tube with water in a syringe, then administered the medication diluted in water. LN 6 did not raise the resident's head during medication administration and did not check for residual volume in the feeding tube prior to medication administration. In an interview with LN 6 on 11/4/24, at 4:50 p.m., LN 6 stated Resident 82's head should have been raised by at least 20-30 degrees to prevent aspiration during medication administration. LN 6 stated she did not check the feeding tube residuals because it was ordered to be checked three times a day during each shift. Review of Resident 82's electronic medical record, titled Medication Administration Record (Or MAR, a record that listed doctor's orders for nurses to follow and document), the MAR record indicated the following orders: a. Enteral Feed (same as tube feeding) Order: every shift Enteral - Check Residuals before beginning a feeding and before medication administration. If Greater than 100 cc (CC is an abbreviation for cubic centimeter, a unit of volume in the metric system), HOLD Feedings and Recheck in 1 HR. If not resolved, CALL MD -Start Date 4/13/23. b. Enteral Feed Order: every shift Enteral - Elevate Head of bed at least 30 Degrees during feeding, any medication administration and for 30 minutes after feeding. -Start Date 4/13/23. In an interview with the DON, on 11/5/24, at 3:43 p.m., the DON stated the staff should follow facility's policy and physician's orders. Review of the facility's policy, titled Care and Treatment of Feeding Tube Policy, dated 6/1/24, the policy indicated It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complication to the extent possible . The Resident's plan of care will address the use of feeding tube, including strategies to prevent complications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069 Based an observation, interview and record review, the facility failed to ensure one out of 25 sampled residents (Resident 29) received treatment and care in accordance with professional standards of practice, and facility's policy and procedure (P&P) when Resident 29's physician's order for G-Tube Insertion Site (Gastronomy tube-a tube used to provide nutrition and medications) treatment was not followed. This failure had the potential for Resident 29's G-tube insertion site to become infected and for Resident 29 to not achieve their highest practicable well-being. Findings: Resident 29 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and as having a G-Tube. During a review a Resident 29's physician orders contained an order dated 5/10/24 for Enteral - Cleanse G Tube Insertion Site QD (every day) with NSS (normal sterile saline), pat dry, cover with gauze or abdominal pad. Monitor and report to MD if s.s. (signs & symptoms) of worsening. every day shift. During a concurrent observation and interview on 11/6/24 at 9:51 a.m., with Licensed Nurse (LN) 1, Resident 29's G-Tube was observed with no gauze or abdominal pad on the insertion site. LN 1 confirmed the G-Tube insertion site should have gauze on it. During a review of the facility's policy and procedure (P&P) titled, Provision of Physician Ordered Services, dated 3/1/23 indicated, The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. "Professional Standards of Quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. During a review of the facility's P&P titled, Care and Treatment of Feeding Tube Policy, dated 6/1/24 indicated, It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47197 Based on observation, interview, and record review, the facility failed to provide pressure injury/ulcer (PI/PU, injury to skin and underlying tissue resulting from prolonged pressure) care and treatment consistent with professional standards of practice and facility's policy and procedures (P&P) for one of 25 sampled residents (Resident 89) when Resident 89's newly applied pressure ulcer dressing was not initialed and dated. This failure has the potential for Resident 89's stage 4 PU (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) to not get ordered care and treatment, to get worse, and/or develop complications, and for Resident 89 to not achieve the highest practicable well-being. Findings: A review of Resident 89's clinical record indicated Resident 89 was admitted March of 2023 and had diagnoses that included stage 4 PU of sacral region (lower back near the crease of the buttocks), severe malnutrition, muscle weakness, and need for assistance with personal care. A review of Resident 89's Admission Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 10/24/24, indicated Resident 89 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 14 out of 15 which indicated Resident 89 had intact cognition. A review of Resident 89's MDS Skin Conditions, dated 10/24/24, indicated Resident 89 was at risk of developing pressure ulcers/injuries, had one unhealed Stage 4 PU, and had treatments which included pressure reducing device for bed, PU/PI care, and application of ointments/medications, and nonsurgical dressings. During an interview on 11/4/24 at 9:37 a.m. with Resident 89, Resident 89 stated he has a wound on his bottom area and was receiving treatment daily. A review of Resident 89's active physician's order, dated 10/23/24, indicated, Sacrum [sacral region] stage 4 PI: Cleanse with NS [normal saline- a mixture of water and salt] +Vashe [wound cleanser], apply collagen followed by opticell AG [an antibacterial wound dressing] and cover with foam sacral dressing. every day shift for SACRAL PRESSUR ULCER During a concurrent wound treatment observation and interview on 11/6/24 at 9:37 a.m., with Treatment Nurse (TN)1, TN 1 cleansed Resident 89's stage 4 sacral PU, applied ordered treatment, and covered it with a waterproof foam dressing. TN 1 did not label the dressing with her initials and the date of treatment. TN 1 confirmed the observation and stated she should have initialed and dated the wound dressing. During an interview on 11/6/24 at 12:26 p.m., with TN 2, TN 2 stated she would expect wound dressings to be dated and initialed so staff would know what date the dressing was changed and who did the dressing change. TN 2 further stated if a wound dressing is not labelled with initials and date, it would be a risk for infection because staff would not know when exactly the wound dressing was changed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 2:03 p.m. with the Infection Preventionist (IP), the IP stated wound dressings should be dated and initialed to let the staff know if the wound dressing was really changed. During an interview on 11/6/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated she would expect that newly applied wound dressings would be initialed and dated to verify for the next nurse that the treatment was completed. The DON further stated that labeling a wound dressing with initials and date is an extra layer of making sure that the ordered treatment was done and was followed. A review of the facility's P&P titled, Clean Dressing Change, dated 7/1/23, indicated, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination .16. Secure dressing. [NAME] with initials and date.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 39489 Based on observation, interview and record review, the facility failed to follow a physician's order for care of a feeding tube (a tube placed in the gastrointestinal (GI) tract to deliver nutrition and calories (enteral nutrition) to your body if you can't safely chew or swallow), when a water flush (water given to hydrate patients via enteral feeding tube) volume and frequency received by Resident 107 was not consistent with the physician's order for one (Resident 107) of 25 sampled residents. This deficient practice placed Resident 107 in danger of receiving incorrect amounts of water flushes and may have resulted in depleted nutrition. Findings: A review of Resident 107's Admission Record, indicated, Resident 107 was admitted in the facility in October 2024 and had diagnoses that included Type 2 Diabetes (high blood sugar), Dysphagia (difficulty swallowing), and the need for assistance with personal care. A review of Resident 107's Brief Interview for Mental Status, Section C, (BIMS, cognitive screening test), indicated, Resident 107 was unable to complete the interview. During an observation in Resident 107's room, on 11/4/24 at 11 a.m., the water flush in the kangaroo epump (medical device that delivers enteral [enteral means intestines or digestive system] feeding and hydration to patients) was programmed at 150ml (ml, unit of measurements) every 6 hours, but on the water flush bag dated 11-3-24, it was labeled at 200ml every 4 hours. During a review of Resident 107's Order Summary, dated 11/1/24, indicated ., Water flush 200mls Q [every] 4 hrs . During an interview with License Nurse 10 (LN 10) at Resident 107's room, on 11/6/24 at 9:50 a.m., LN 10 confirmed water flush was at 150ml every 6 hours as indicated/programmed in the kangaroo epump but in the water flush bag, it was labelled at 200ml every 4 hours. LN 10 stated the volume and frequency of water flush did not match. During a record review of Resident 107's eMar (electronic medication administration record) with LN 10 on 11/6/24 at 10:35 a.m., LN 10 acknowledged, the physician's order on 11/1/24 was 200cc flush water every 4 hours but currently the kangaroo pump was programmed to 150cc flush water every 6 hours. LN 10 stated, the current order should have been followed, it should show in the pump 200cc flush water every 4 hours, resident is getting less fluids, not the correct volume and frequency of flush, yes, we're not following the doctor's order. During an interview with the Director of Nursing (DON), on 11/7/24 at 12:05 p.m., the DON stated, My expectation from the nurses is to follow physician's order, and it should reflect on Resident 107's pump and water flush bag. (continued on next page)

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Capital Post Acute	6821 24th Street Sacramento, CA 95822

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Care and Treatment of Feeding Tube Policy, dated 6/1/24, indicated, .Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 47197 Based on observation, interview, and record review, the facility failed to ensure proper storage, handling, labeling, and delivery of respiratory care and equipment consistent with the facility's policy and procedures (P&P) for three out of 25 sampled residents (Resident 105, Resident 23, and Resident 88) when: 1. Resident 105's nebulizer (machine that turns liquid medicine into a mist that can be easily inhaled) mask and tubing set was left on top of the bedside drawer, uncovered after use and was not changed after 72 hours; 2. Resident 23's nebulizer mask and tubing set was left on top of the bedside drawer, uncovered after use; and, 3. Resident 88's physician's order for oxygen therapy was not followed, and Resident 88's nasal cannula (a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) and humidifier bottle (a device prefilled with water that adds moisture to oxygen to make it more comfortable and effective to breathe) were not labeled with the date it was first used. These failures had the potential to result in unsafe and unsanitary delivery of nebulizer medication to Resident 105 and Resident 23, and oxygen to Resident 88. Findings: 1. A review of Resident 105's clinical record indicated Resident 105 was admitted October of 2024 and had diagnoses that included parkinsonism (a clinical syndrome characterized by tremor, slowed movement, rigidity, and postural instability), asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe), dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 105's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 10/18/24, indicated Resident 105 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 105 had moderately impaired cognition. A review of Resident 105's MDS Health Conditions, dated 10/18/24, indicated Resident 105 had experienced shortness of breath or trouble breathing when lying flat. A review of Resident 105's physician's order, dated 10/16/24, indicated, Ipratropium-Albuterol Solution [a liquid medicine used to prevent and treat symptoms caused by lung diseases which is administered via nebulizer] . 1 vial (a glass container used for holding liquid medicines) inhale orally via nebulizer four times a day for Asthma WAIT 5 MINUTES BEFORE GIVING ANOTHER INHALER/NEBULIZER SOLUTION. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/4/24 at 10:50 a.m. in Resident 105's room, Resident 105 was currently not in his room. A nebulizer mask and tubing set hooked to a nebulizer machine was observed left on top of the bedside drawer, uncovered. Nebulizer mask and tubing set indicated it was last changed on 10/27. During a concurrent observation and interview on 11/4/24 at 10:53 a.m. with Licensed Nurse (LN) 3 in Resident 105's room, LN 3 confirmed that Resident 105's nebulizer mask and tubing set was left on top of the bedside drawer, uncovered, and was last changed on 10/27. LN 3 stated the nebulizer mask and tubing set should be placed in a bag when not being used and should be changed every 72 hours to prevent it from contamination and for infection control. 2. A review of Resident 23's clinical record indicated Resident 23 was admitted November of 2019 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) following nontraumatic intracerebral hemorrhage (a condition where a pool of blood is formed within the brain causing structural, biochemical or electrical abnormalities in the brain, spinal cord, or other nerves) affecting left non-dominant side, diabetes mellitus (a chronic condition causing too much sugar in the blood that can affect lung function and breathing), and shortness of breath. A review of Resident 23's MDS Cognitive Patterns, dated 9/17/24, indicated Resident 23 had a BIMS score of 9 out of 15 which indicated Resident 23 had moderately impaired cognition. A review of Resident 23's physician's order, dated 1/8/24, indicated, Ipratropium-Albuterol Solution .3 ml [milliliters- unit of measurement] inhale orally every 4 hours as needed for SOB [shortness of breath] .via nebulizer. During a concurrent observation and interview on 11/4/24 at 10:57 a.m. with Resident 23 in Resident 23's room, Resident 23's nebulizer mask and tubing set hooked to a nebulizer machine was observed left on top of the bedside drawer, uncovered. Resident 23 confirmed the observation and stated he last used the nebulizer mask and tubing set yesterday. During a concurrent observation and interview on 11/4/24 at 10:5 a.m. with Certified Nurse Assistant (CNA) 1 in Resident 23's room, CNA 1 confirmed that Resident 23's nebulizer mask and tubing set was left on top of the bedside drawer, uncovered. CNA 1 stated, .They [facility] have not told us [CNAs] anything about putting it [nebulizer mask and tubing set] in a bag when not in use . A review of Resident 23's Medication Administration Record (MAR-a document that listed administered drugs) for the month of November 2024 indicated Resident 23 last received Ipratropium-Albuterol Solution via nebulizer on 11/3/24 at 4:49 p.m. During an interview on 11/6/24 at 2:03 p.m. with the Infection Preventionist (IP), the IP stated, .when it's [nebulizer mask and tubing set] not being used, it should be in an antimicrobial bag to prevent contamination . the set-up [nebulizer mask and tubing set] is changed once a week .It's a risk of infection if not being changed regularly. (continued on next page)

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Capital Post Acute	6821 24th Street Sacramento, CA 95822

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated the nebulizer mask and tubing set should be placed in an antimicrobial bag when not being used for infection control. The DON further stated, I believe it's [changing of nebulizer mask and tubing set] 7 days . for infection control. A review of the facility's P&P titled, Oxygen Administration, dated 5/1/23, indicated, .5 .Other infection control measures include: .d . change nebulizer tubing and delivery devices every 72 hours .e. Keep delivery devices covered in a plastic bag when not in use. A review of the facility's P&P titled, Oxygen Administration Infection Prevention, dated 5/1/23, indicated, Infection Control Considerations Related to Medication Nebulizers .7. Store the circuit in bag, marked with date and resident's name, between uses. 3. A review of Resident 88's clinical record indicated Resident 88 was admitted March of 2024 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), asthma, and shortness of breath. A review of Resident 88's MDS Cognitive Patterns, dated 9/9/24, indicated Resident 88 had a BIMS score of 15 out of 15 which indicated Resident 88 had intact cognition. A review of Resident 88's MDS Health Conditions, dated 9/9/24, indicated Resident 88 had experienced shortness of breath or trouble breathing when lying flat. A review of Resident 88's MDS Special Treatments, Procedures, and Programs, dated 9/9/24, indicated Resident 88 had oxygen therapy while he is a resident in the facility. A review of Resident 23's physician's order, dated 6/7/24, indicated, Oxygen at 2 LPM [liters per minute- unit of measurement for oxygen administration flow rate] via Nasal Canula continuous every shift for monitoring. During an observation on 11/4/24 at 11:13 a.m. in Resident 88's room, Resident 88's was observed using an oxygen concentrator set at 4 lpm delivered via nasal cannula. Resident 88's nasal cannula and humidifier bottle were not labeled with the date of when it was first used. During a concurrent observation and interview on 11/4/24 at 4:22 p.m. with LN 6 in Resident 88's room, LN 6 confirmed that Resident 88's nasal cannula, and humidifier bottle were not labeled with the date it was first used. LN 6 also confirmed that Resident 88's oxygen flow rate was set at 4 lpm. LN 6 stated that the humidifier bottle and nasal cannula should be labelled with the date it was first used. LN 6 further stated the nasal cannula should be changed every Sunday for infection control. During a concurrent observation and interview on 11/5/24 at 10:25 a.m. with LN 3 in Resident 88's room, LN 3 confirmed that Resident 88's oxygen flow rate was set at 4 lpm. LN 3 stated, It's [Resident 88's oxygen flow rate] should be 2 lmp .It can cause hyperoxygenation (a condition in which the body is exposed to an unusual amount of oxygen causing respiratory and/or neurological problems) .and can affect her [Resident 88] health. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 2:03 p.m. with the IP, the IP stated, .Nasal cannula and humidifier bottle . all tubing, should be labelled [with the date it was first used] .It [first used date label] gives [facility] staff a reference on changing them [nasal cannula, humidifier bottle, and other respiratory tubing], which is once a week or as needed. During an interview on 11/6/24 at 3:46 p.m. with the DON, the DON stated she would expect the physician's order for oxygen therapy to be followed. The DON further stated she also expects that nasal cannula and humidifier bottle would be labeled with when it was first used because nasal cannula and humidifier bottle needs to be changed out within a specific time frame. A review of Resident 88's active care plan and interventions, undated, indicated, The resident [Resident 88] has oxygen therapy as ordered .Give medications [oxygen] as ordered by physician .OXYGEN SETTINGS: O2 [oxygen] via (SPECIFY: nasal prongs) @ 2L [lpm] continuous . A review of the facility's P&P titled, Oxygen Administration, dated 5/1/23, indicated, Oxygen is administered to residents .consistent with professional standards of practice, the comprehensive person-centered care plans .1. Oxygen is administered under orders of a physician .5 .Other infection control measures include: .b. Change oxygen tubing and . cannula weekly .c. If indicated change the humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 Based on observation, interview, and record review the facility failed to ensure Resident 94's medically related social services needs were met when, Social Services Assistants (SSA) did not clarify his surgery with his primary physician for one of 25 sampled residents, Resident 94. This failure had the potential to cause delay in Resident 94's healing and recovery. Findings: During a review of Resident 94's Admission Record (AR), the AR indicated Resident 94 was admitted to the facility in March 2024 with diagnoses that included cerebral infarction (disrupted blood flow to the brain), and dysphagia (difficulty of swallowing) following cerebral infarction and depression. During a review of Resident 94's summary score for Brief Interview for Mental Status (BIMS, cognitive screening test) was 12 out of 15 which indicated Resident 94 had moderately impaired cognitive function. During an interview with Resident 94 on 11/4/24 at 10:30 a.m., Resident 94 stated, together with her husband, she had an appointment with [physician's name] in [DATE] and discussed the plan for cranioplasty surgery (repair of an injury to the skull). When they came back to the facility, they brought back paperwork and a surgical kit prep and gave it to the nurse who kept it in the med room (medication room). Resident 94 further stated, she mentioned it to the nurses and Social Services staff and reminded them to call the clinic to find out the date for the surgery, but they never followed up on it. My husband reminded them too, but nothing happened up to this day. During an interview with License Nurse 4 (LN 4), on 11/6/24 at 10:55 a.m., LN 4 acknowledged, Resident 94 had an appointment with [physician's name] in August 2024 with her husband, and when they came back from the clinic, they brought back paperwork and surgical kit prep. LN 4 stated, the surgical kit prep was kept in the medication room and stated we should have followed up and clarified with the clinic about the surgery. She further stated she heard Resident 94 and her husband mention possible surgery for Resident 94, and they said, we [staff] should call the clinic to find out the date. During an interview with the Responsible Party (RP) on 11/6/24 at 3:46 p.m., RP stated, In [DATE] he accompanied Resident 94 for her doctor's appointment and told the staff she should have a follow up to do the surgery. I've been reminding the nurses and the SSA that Resident 94 needs to see [physician's name] again, but nobody followed up, it is now November, and we're still waiting, we have no idea what's going on. We want her home, after the surgery. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the SSA 1 and SSA 2 on 11/6/24 at 4:06 p.m., SSA 1 and SSA 2 confirmed Resident 94 was accompanied by her husband and was seen by [physician's name] in [DATE], and came back from the physician's clinic with paperwork and a surgical kit prep. SSA 1 and SSA 2 acknowledged that Resident 94 and her husband mentioned to them that they need to call the clinic to clarify the date for Resident 94's surgery. SSA 1 stated, the RP spoke to me last week and told me Resident 94 should have a follow up with [physician's name] about Resident 94's surgery. SSA 1 acknowledged she did not call the clinic. SSA 2 also stated, she spoke with RP in the last week of October and told me Resident 94 should see [physician's name] to do the surgery. Both SSA 1 and SSA 2 agreed Resident 94 should not have to wait this long [from Aug to Nov] to wait for an answer about the surgery. During an interview with the Director of Nursing (DON), on 11/7/24 at 12:05 p.m., the DON stated her expectations from the Social Services staff is to follow up with the clinic to clarify the surgery date and ask why Resident 94 was given a surgical kit prep. During a review of Resident 94's Progress Notes, dated 8/26/24, indicated, Resident had Neurosurgery appt today at Kaiser South accompanied by Husband transported by Modivecare via gurney. Came back to the facility, pt, in stable condition. No new order given in the packet that was sent to the appointment, but per pt, and husband RP, will have surgery but no schedule given at this time. Was given a surgical kit prep, placed at Med Room for safety. During a review of the facility's, Job Description: of Social Service, undated, indicated, ., The primary purpose of your job position is to assist in planning, developing, organizing, implementing evaluating, and directing social service programs in accordance with current federal, state, and local standards, guidelines ., to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40903 Based on observation, interview, and record review the facility failed to ensure safe pharmaceutical services with a census of 112 when: 1. Hazardous medications (drugs that can cause harm to the body when handled unsafely) were stored in the medication carts with no warning label on how to be handled by nursing staff. 2. Emergency Kit (Ekit, a supply of medication used for urgent needs of residents) for oral and injectable medications in both medication rooms were opened and were not replaced in timely manner. 3. Prescription and narcotic medication delivery manifest or receipts from provider pharmacy were not signed by licensed staff for accountability. 4. Medication destruction for non-controlled prescription drugs were not consistently co-signed by two licensed staff and controlled drug destruction log did not include chain of custody with date and final destruction information. 5. Resident 108's controlled drug (drug with potential for abuse) use and removal from Controlled Drug Record or CDR (a paper log of controlled drug removal for administration to resident) was not accurately documented in the resident electronic medical record and Medication Administration Record or MAR (a document that listed administered drugs). 6. Resident 63's controlled medications use and removal from CDR were not accurately documented in the MAR. These failed practices may contribute to unsafe medication use and risk of drug diversion. Findings: 1a. During a medication administration observation, in facility's unit 1-2, accompanied by Licensed Nurse (LN) 3, on 11/4/24, at 10:10 AM, LN 3 crushed a medication called finasteride (a hormone like drug used to treat prostate issues) along with other medications with bare hands. The medication label and the MAR did not instruct how the medication should have been handled by the nurse. In an interview with LN 3, on 11/5/24, at 10:30 AM, LN 3 stated she did not know finasteride was hazardous and should not have been crushed. LN 3 stated the MAR record did not have the warning or comments not to crush or handle with gloves. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. During a concurrent inspection of facility's medication Cart #6, in the Sub-Acute Unit, accompanied by LN 11, on 11/5/24, at 10:10 AM, the cart on the bottom drawer stored a bottle of liquid medication called Valproic Acid (or Divalproex, a medication used to treat mood disorder or seizure [uncontrolled brain activity]) in a dark colored bottle with traces of spills on the outer bottle and the label. The Valproic bottle did not have a hazardous warning label for handling and was not contained in a Ziplock bag. LN 11 stated the Hazardous label would have prompted her to use gloves when using the product, similar to other products in the cart. 1c. During a concurrent inspection of facility's medication Cart #4, in the middle Unit, accompanied by LN 12 on 11/5/24, at 2:30 PM, the cart stored a medication in the bubble pack form called anastrozole (a hormone like cancer drug) without any hazardous labeling on how it should have been handled. The small label on the bubble pack indicated, Do not use if you are pregnant . LN 12 acknowledged no warning label on if the nurse should be wearing gloves when handling this cancer drug. In an interview with Director of Nursing (DON), on 11/7/24, at 9:03 AM, the DON stated the facility did not have a policy on hazardous medication use and handling. The DON stated the facility needed to work on it and educate staff on safe handling of hazardous medications. Review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, a federal agency sets standard of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 4/2023, the document indicated Many . drugs intended for individual use can be hazardous to healthcare workers with potential occupational exposure to those who handle, prepare, dispense, administer, or dispose of these drugs. Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes. PPE (or Personal Protective Equipment, items like glove or mask) provides worker protection to reduce exposure to hazardous drugs. Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. NIOSH suggests careful precautions and safeguards to protect workers, fetuses, and breastfed infants. Further review of the document indicated to use single glove for handling intact tablet form and double glove for handling oral liquid form of the hazardous medications as directed. Review of the drug information for finasteride, valproic acid and anastrozole, last accessed via Lexicomp (an online drug information resource) on 11/2024, the drug information indicated the following: Hazardous Drugs Handling Considerations: Hazardous agent (NIOSH .). Use appropriate precautions for receiving handling, storage, preparation, dispensing, transporting, administration, and disposal . 2. During a concurrent inspection of facility's Back station medication room, accompanied by LN 8 on 11/4/24, at 10:20 AM, the EKit for oral medications had a yellow seal indicating that it has been opened and used. When the Ekit was opened, a paper log inside indicated it was last used on 10/31/24, at 8 PM. LN 8 stated the Ekit should been replaced within 72 hours. LN 8 stated she was not sure if the pharmacy had been notified as the sticker on outer label was still on the box and the duplicate copy of the removal sheet was not faxed to pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and inspection of facility's Front station medication room, accompanied by LN 7 on 11/4/24, at 10:54 AM, the EKit for injectable medications (drugs given as a shot into skin or veins) had a yellow seal indicating that it has been opened and used. When the Ekit was opened, a paper log inside indicated it was last used on 10/31/24, at 8 PM for removal an antibiotic. LN 7 stated the Ekit stated she was not sure why not replaced. In an interview with Director of Nursing (DON), in her office, on11/5/24, at 3:43 PM, the DON stated the staff should have called provider pharmacy directly to replace the Ekit right after a drug removal. The DON stated the facility's policy required the Ekit replaced within 72 hours. Review of the facility's policy, titled Emergency Medication Policy, dated 5/1/23, the policy indicated Any medication that is removed from the emergency kit must be documented on emergency medication administration log. Medication and supplies used from emergency medication kit must be replaced upon next routine drug order. 3. During a concurrent interview and inspection of facility's Back station, accompanied by LN 9 on 11/4/24, at 10:20 AM, the medication delivery manifests from the provider pharmacy, titled Consolidated Delivery Sheets, were reviewed. The records from month of November 2024 included prescription and narcotic medications delivery documents. LN 9 stated the nurses signed the delivery driver's record. LN 9 was not sure how the delivery medications were compared with the manifest. LN 9 acknowledged the facility's delivery sheet were not signed and dated by licensed nurses. In an interview with Director of Nursing (DON), in her office, on 11/5/24, at 3:56 PM, the DON stated the medication delivery sheets should have been signed by nursing staff for accuracy and accountability. Review of the facility's policy, titled Medication Ordering and Receiving From Pharmacy, dates 4/2008, the policy indicated The dispensing pharmacy will transport medication through the facility in a manner that prevents contamination, degradation, and diversion of medication . Upon arrival at the facility, the courier delivers the medication directly to licensed nurse. The pharmacy provides a method for both parties to confirm delivery. The pharmacy should be notified within 24 hours regarding any discrepancy or respect to medication delivery. 4a. During a concurrent interview and review of facility's document, titled Medication Disposition Record/Pass Log, at the back station, accompanied by LN 9 on 11/4/24, at 10:20 AM, the medication destruction record for non-controlled drugs were reviewed and three pages of medication destruction dated 10/13/24 did not have a witness signature by a licensed nurse. LN 9 acknowledged the finding. In an interview with Director of Nursing (DON), in her office, on 11/5/24, at 3:35 PM, the DON stated there should have been a witness signature for destruction and disposition of medications. Review of the facility's policy, titled Discarding and Destroying Medications, dated 5/1/23, the policy indicated medications that cannot be returned to dispensing pharmacy . are disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceutical, hazardous waste and controlled substances. The Policy on section 10 indicated The medication disposition record contains as minimum the following information . and signature of witnesses. (continued on next page)

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	555442	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Post Acute	6821 24th Street Sacramento, CA 95822

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4b. During a concurrent interview and record review with DON, in her office, on 11/5/24, at 3 PM, the DON stated the controlled drugs were stored in her office in a locked cabinet and were destroyed with the pharmacist. The DON stated she was following previous leadership at the facility and kept a recorded book that logged the drug name, quantity, and signature of nurse that handed her the controlled drug. The record did not show chain of custody from nurse to DON and destruction witness with the pharmacist. The record further did not have the dates of destruction consistently. The DON stated the pharmacist's signatures were recorded in the Controlled Drug Record sheet which were stored in the individual residents' charts. The DON did not provide examples of recent destruction records. In a telephone interview with Consultant Pharmacist (CP), on 11/7/24, at 12:53 PM, the CP stated she followed the facility's system of controlled drug destruction on making sure the CDR and actual controlled drug quantity were matched for disposition. The CP was not sure how the CDR sheets were filed and how the DON kept track of the recordings in the logbook. Review of the facility's policy, titled Discarding and Destroying Medications, dated 5/1/23, the policy indicated All unused controlled substances are retained in securely locked area with restricted access until disposed of . control substances are disposed of in accordance with state regulation and federal guidelines regarding disposition of nonhazardous controlled medications. The policy on section 10 indicated The medication disposition record contains, as a minimum, the following information: a. The residents name, b. the name and strength of the medication, c. The prescription number, (if any), d. The name of the dispensing pharmacy, e. The date medication destroyed, f. The quantity destroyed, g. Method of destruction, h. Reason for destruction, i. Signature of witnesses. Completed medication disposition records are kept on file in the facility for at least two years or as mandated by state law governing the retention and storage of such records. 5. A comparative review of the Resident 108's Controlled Drug Record use and documentation in the MAR, with date range of 10/20/24 to 11/4/24, showed the record for oxycodone use (an opioid pain medication) did not accurately reflected medication use and accountability of use. The record indicated oxycodone removal on 10/26/24 from CDR when it was not documented in Resident 108's MAR and was crossed off when the oxycodone count was not corrected. The CDR record additionally indicated one removal between 10/31/24 and 11/1/24 which was crossed off when the actual oxycodone count was not corrected. In an interview with DON, on 11/7/24 at 9 AM, the DON stated Resident 108's oxycodone documentation on 10/26/24 was erroneously documented. The DON could not explain the accuracy of oxycodone count as it was crossed out without count correction. Review of the facility's policy, titled Medication Administration, dated 3/1/23, the policy indicated Review MAR to identify medication to be administered. Compare medication source . with MAR to verify resident name, medication name, form, dose, route, and time . Sign MAR after administered . If a medication is a controlled substance, sign narcotic book . Correct any discrepancy and report to nurse manager . and/or DON. 47197 (continued on next page)

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Capital Post Acute	6821 24th Street Sacramento, CA 95822

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A review of Resident 63's clinical record indicated Resident 63 was admitted June of 2022 and had diagnoses that included hepatic failure (occurs when the liver is unable to perform its normal functions), chronic pain, diabetes mellitus (a chronic condition causing too much sugar in the blood that can affect nerves), and neuropathy (a nerve condition that can cause pain, numbness, tingling, or weakness in the body). A review of Resident 63's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 10/23/24, indicated Resident 63 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 63 had an intact cognition. A review of Resident 63's MDS Health Conditions, dated 10/23/24, indicated Resident 83 had experienced pain occasionally and had received scheduled and as needed pain medication regimen, and non-medication intervention for pain. A review of Resident 63's physician's order, dated 10/27/24, indicated, oxyCODONE HCl [a controlled pain medication] Oral Tablet 10 MG [milligrams- unit of measurement] .Give 10 mg by mouth every 4 hours as needed for chronic pain. A random audit of Resident 63's MAR and the CDR for oxycodone, for the month of October 2024, indicated nursing staff did not document oxycodone administration on the MAR when signed out from CDR as follows: 1 tablet on 10/2/24 at 9:35 p.m., 1 tablet on 10/7/24 at 11:46 a.m., 1 tablet on 10/14/24 at 5:17 a.m., 1 tablet on 10/14/24 at 9:15 p.m., 1 tablet on 10/16/24 at 2:39 a.m., 1 tablet on 10/16/24 at 9:59 p.m., 1 tablet on 10/20/24 at 10:30 p.m., 1 tablet on 10/22/24 at 10:35 p.m., 1 tablet on 10/27/24 at 10:15 p.m., and 1 tablet on 10/28/24 at 10:30 p.m. During a concurrent interview and record review on 11/7/24 at 9:16 a.m. with Licensed Nurse (LN) 5, Resident 63's CDR and MAR for October 2024 were reviewed. LN 5 confirmed the finding of oxycodone being signed out of the CDR but was not accurately documented on the MAR on 10 occasions. LN 5 stated, . We [facility staff] would sign out the medication [oxycodone] on both [CDR and MAR] .I sign it out here [CDR] and then the MAR. LN 5 further stated signing out oxycodone on the CDR and MAR is part of being accountable of the controlled medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/7/24 at 9:30 a.m. with the Director of Nursing (DON), Resident 63's CDR and MAR for October 2024 were reviewed. The DON confirmed the finding of oxycodone being signed out of the CDR but was not accurately documented on the MAR on multiple occasions. The DON stated the process should be staff would sign out controlled medication both in CDR and MAR. The DON further stated, It's [CDR and MAR does not reconcile] a problem with the accuracy of documentation .It [CDR and MAR] should reconcile, both signed off in the MAR and here [CDR]. During an interview on 11/7/24 at 11:40 a.m. with the Consultant Pharmacist (CP), the CP stated, No, I'm not aware of that [Resident 63's CDR and MAR does not reconcile] . The implication .record [CDR and MAR] is not accurate and possible theft [of controlled medication]. The CP further stated it would be a risk of controlled medication diversion if the CDR and MAR would not reconcile and signing out the medication on the CDR and MAR is part of accountability of the controlled medication. A review of the facility's P&P titled, Medication Administration, dated 3/1/23, indicated, .17. Sign MAR after administered .18. If medication is a controlled substance, sign narcotic book [CDR].

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40903 Based on observation, interview, and record review the facility failed to ensure safe medication administration practices when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with Resident census of 112. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of three errors out of 37 opportunities which resulted in a facility wide medication error rate of 8.11 % in two out of 10 residents (Resident 69 and Resident 105) observed for medication administration. These failures may result in unsafe medication use, medication error, and use of spoiled or ineffective drugs. Findings: During a medication administration observation, in facility's Units 1-2, accompanied by Licensed Nurse 3 (LN 3), on 11/4/24, at 9:38 a.m., LN 3 administered a total of seven medications to Resident 105. LN 3 pulled a unit of liquid inhalation medication called DuoNeb (a combination product with albuterol-ipratropium used to treat shortness of breath or asthma), which was out of the foil pouch, and instilled the liquid in the inhalation device for Resident 105 to inhale (breath in). The DuoNeb box was pen-marked with open date 10/16/24. In a concurrent interview and record review, with LN 3, on 11/5/24, at 10:30 a.m., LN 3 stated she did not realize the DuoNeb product labeling indicated Once removed from the from the foil pouch, the individual vials should be used within two weeks. During a medication administration observation, in the facility's Units 1-2, accompanied by LN 3, on 11/4/24, at 10:10 a.m., LN 3 administered a total of eight medications to Resident 69. LN 3 with bare (ungloved) hand crushed seven pills including two products as follow: Aspirin EC 81 mg (EC stands for Enteric Coated, mg is milligram, a unit of measure) and Finasteride 5 mg (a hormone like drug used to treat prostate issues). In a concurrent interview and record review, with LN 3, on 11/5/24, at 10:30 a.m., LN 3 stated she forgot not to crush the enteric coated aspirin and did not know finasteride should not be crushed, in addition to be a hazardous drug for crushing and handling. LN 3 confirmed the order to crush was for medications that were qualified to be crushed based on manufacturer or safe medications use and handling. LN 3 stated the Medication Administration Record (or MAR- a record that guide the nurses for medication administration) did not have the warning to tell the nursing staff not to crush and handle hazardous drugs with gloves. In an interview with Director of Nursing (DON), in her office, on 11/5/24, at 3 p.m., the DON stated the nursing staff were trained upon hire on medication administration workflow and they should follow the computer prompts like enteric coated to tell them if a product is non-crushable. The DON stated the nursing staff if not familiar with a drug they can google (a free online search website for information) it or look at the drug book. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of online drug information by Pharmacist Letter, titled Meds That Should Not Be Crushed, updated in February 2023, last accessed via https://pharmacist.therapeuticresearch.com/Content/Segments/PRL/2014/Aug/Meds-That-Should-Not-Be-Crushed-7309, on 11/12/24, the document indicated aspirin Enteric Coated (or Ecotrin) and finasteride (or Proscar) among the drugs that should not be crushed. The document further indicated Crushing delayed-release meds can alter the mechanism designed to protect the drug from gastric acids or prevent gastric mucosal irritation . Crushing irritating or hazardous meds (medication that pose health risk when handled without protective measures) can be harmful to the individual crushing the meds . Hazardous meds . explicitly state not to crush in the product information. Review of the facility's policy, titled Medication Administration, dated 3/1/23, the policy on section 14 indicated Administer medications as ordered in accordance with manufacturer's specification. Crush medications as ordered. Do not crush medication with do not Crush instruction.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48175 Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices were maintained in the medication room and medication carts with the census of 112 when: 1. The Back Station medication room stored expired, unlabeled, and undated medications. 2. Medication Cart #2 found a pill in the pill cutter, and Pro-Stat AWC had yellow/orange streaks running down the bottle. 3. Hazardous medications (drugs that can cause harm to the body when handled unsafely) were stored in medication Carts # 1 and Cart #4 with no warning label on how to be handled by nursing staff. 4. Inhalation products called Ipratropium Bromide and Albuterol Sulfate (or DuoNeb, a breathing treatment) stored in medication Cart #1 and Cart #4 were not dated, and/or the beyond use date was not followed. These failures had the potential to negatively impact the residents' well-being and the use of spoiled or expired medications. Findings: 1. During a concurrent observation and inspection on, 11/4/24 at 10:27 a.m., at the Back Station medication room, accompanied by Licensed Nurse 8 (LN 8), the medication room stored expired, unlabeled, undated medications, and unsafe storage practices in the active storage areas as follows: i. Osmolite bottle (a nutritional feeding product in liquid form) with an expiration date of 11/1/24 stored in active storage areas. ii. Omeprazole liquid bottle 2 mg/ml (mg/ml is milligram/milliliter - a metric unit of measurement used for medication dosage and/or amount, a drug used for stomach ulcer) was stored in the refrigerator in active storage areas with an open date of 10/1/24 and discard after 30 days on the product label. iii. House supply of Aplisol Tuberculin Purified Protein (product used to test for TB (or tuberculosis)- a serious lung infection) was undated when first opened; the Label says, Once entered (opened for the first time), the vial should be discarded after 30 days. iv. The influenza vaccine (Afluria brand name, 2024-2025 formula) was outdated, with an open date of 9/20/24. The product label on the box indicated, Once entered, the vial should be discarded after 30 days. v. A staff drink bottle was found in the freezer section of the medication refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vi. Two Intravenous (IV-fluids given directly into the bloodstream) bags of Lactated Ringer's solution (LR-helps replace fluids and minerals), 1000 ml [milliliters] (ml-unit of volume), were sitting on the medication room counter. They had no resident-specific label or name. LN 8 stated she could not tell who the IV bags were used for. LN 8 concurred with the findings in the Back Station medication room and removed the products from active storage areas. 2. During a concurrent observation and inspection on 11/4/24, at 12:14 p.m., on medication Cart #2, accompanied by LN 7, the following was found: i. The pill cutter stored in the top drawer of the cart contained white powder and a pink pill (half a tablet). LN 7 was unsure when it was last used and stated that it should not have been there. ii. The pro-Stat AWC (dietary management to increase protein) bottle had yellow/orange streaks of sticky liquid running down the outer bottle. LN 7 stated, That [Pro-Stat AWC] should be wiped down after it has spilled over . 3. During a concurrent observation and inspection of medication Cart #6, on 11/5/24, at 10:08 a.m., in the Sub Acute Unit, accompanied by LN 11, the cart stored one bottle of medication in liquid form called Depakene (used to treat seizure disorders), in the bottom drawer and the liquid Depakene had spilled all over the bottle which was sticky to touch. The label on the Depakene liquid bottle did not have any auxiliary information for hazardous drugs or how they should have been handled by nursing staff. The Depakene bottles were not stored in a Ziplock bag to prevent hand contamination during storage. LN 11 was unaware of safe handling and did not know this medication should have been labeled for safe handling. 4. During a concurrent observation and inspection of medication Cart #4, on 11/5/24, at 2:30 p.m., at the Back Station, accompanied by LN 12, the medication cart stored a bubble pack (medication packaged in a flat unit dose) of medication called Arimidex (same as anastrozole, used to treats breast cancer). The label on the bubble pack for Arimidex did not have any auxiliary information for hazardous drugs or how they should have been handled by nursing staff. Further inspection indicated storage of two boxes of opened inhalation products called Ipratropium Bromide and Albuterol Sulfate (or DuoNeb, used for breathing treatment and the symptoms of lung diseases). One box of DuoNeb was undated and was out of overwrap foil. The second DuoNeb box was open and out of overwrap foil dated 10/1/24. The storage information on the package indicated, Once removed from the foil pouch, the individual vials should be used within two weeks . LN 12 stated she didn't realize the breathing treatment was good for two weeks once it was out of the overwrap foil. During an interview on 11/7/24 at 2:28 p.m. with the Director of Nursing (DON), the DON stated that she expected the nursing staff to remove outdated medications from active storage areas and, when indicated, date the products when they are opened. The DON also stated that the date beyond use should be checked and followed by the staff. The DON also stated that there should be instruction on safely handling hazardous medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy & Procedure (P&P) titled, Medication Storage, dated 3/1/23, the P&P indicated, .Ensure all medications housed on our premise will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient .Unused medications: .are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance .with state regulations and federal guidelines .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 17069 Based on observation, interview, and policy review, the facility failed to ensure dishes and utensils were cleaned in a sanitary condition for a census 112. This had the potential for foodborne illnesses. Findings: During an interview on 11/6/24 at 11:18 a.m. with the Dietary Manager (DM) she confirmed the facility had a low temperature dishwasher. During a concurrent kitchen observation and interview on 11/6/24 at 2:09 p.m. the facility's dishwasher had a yellow sign on it indicating it was Low Temperature Dishwasher. The Dietary Aide (DA) 1 was asked to check the dishwasher's sanitizing solution. DA 1 proceeded to take one of the chlorine test strips and dipped in the water of the final rinse cycle. The strip came back less than 10 parts per million (ppm). The DM re-checked chemical strip again less than 10 ppm. The DM confirmed the chemical strip was to be dark color in purple indicating 50 ppm. During a concurrent interview and record review on 11/6/24 at 2:14 p.m. with DA 1, the facility's document titled, Dish Machine Temperature Log (Low Temp Machine) for October and November 20204 was reviewed. There was no documentation the dishwasher's chemical solution was being tested , at least once per shift and recorded. DA 1 confirmed there was no documentation the dishwasher's chemical solution was being tested and documented once a shift. During a review of the facility's policy and procedure (P&P) titled, Dishwasher Policy dated 3/1/23 indicated, It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwater temperatures .All items cleaned in the dishwater will be washed in water that is sufficient to sanitize any and all items .For low temperature dishwaters (chemical sanitization): a. The wash temperature shall be 120 F. b. The sanitizing solution shall be 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse. 5. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40903 Based on interview and record review the facility failed to ensure accurate documentation of Resident 100's diagnosis in the medical records in one out of five residents. This failure of inaccurate documentation of resident's diagnosis may contribute to unsafe care and treatment by the facility and subsequent care providers. Findings: During a concurrent interview with Assistant Director of Nursing (ADON), on 11/7/24, at 11:31 AM, and record review of Resident 100's medical record, titled Discharge Summary, dated 9/30/24, the record indicated Resident 100 had history of dementia (loss of memory) along with other medical diagnoses for heart disease and bedsore infection. The record indicated Resident 100 was ordered olanzapine (or Zyprexa, a mind-altering drug) 2.5 mg (mg is milligram, a unit of measure) at bedtime on discharge from hospital which was a reduced from 7.5 mg previous dosage. ADON acknowledged the indication for use of olanzapine was dementia related behavior. During a concurrent interview with Assistant Director of Nursing (ADON), on 11/7/24, at 11:31 AM, and record review of Resident 100's medical record, titled Physician Progress Note, dated 10/6/24, the record under Assessment/Plan indicated dementia (as a diagnosis), medications reviewed, continue current regimen, monitor and record behaviors. During a concurrent interview with Assistant Director of Nursing (ADON), on 11/7/24, at 11:31 AM, and record review of Resident 100's medical record, titled Nursing Weekly Summary Review, dated 11/3/24, the record under Behavior/Mood section indicated Resident 100 was receiving a mind-altering drug olanzapine at bedtime for dementia behavioral psychological problem m/b (manifested by) shaking fist to people and for bipolar disorder (a mental disease with extreme mood swings). ADON stated she was not sure where the bipolar diagnosis came from. During a concurrent interview with Assistant Director of Nursing (ADON), on 11/7/24, at 11:31 AM, and record review of Resident 100's medical record, titled Psychotropic Medication Consent V.2024, dated 9/30/24, the record for use of olanzapine indicated diagnosis for medication: Anxiety; Target/manifested by behavior: Bipolar. ADON stated the documented indication was not correct and it was signed by the medical doctor. In a telephone interview with Medical Doctor 2 (MD 2), on 11/7/24, at 1 PM, MD 2 stated the nursing staff should follow the documented diagnosis written by medical provider. MD 2 could not comment on the consent document for use of olanzapine he signed with notation of bipolar as an indication. MD 2 stated the diagnosis should come from a medical source otherwise invalid. In an interview with Director of Nursing (DON), on 11/7/24, at 2:30 PM, the DON stated the use of bipolar indications in Resident 100's medical record was inaccurate and an error. The DON stated wrong documentation of a diagnosis could contribute to unsafe care in this and any other health facility the resident may go in the future. (continued on next page)

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	555442	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capital Post Acute	6821 24th Street Sacramento, CA 95822

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's policy, titled Psychotropic Medication Use, dated 6/2021, the policy indicated When a physician/prescriber orders a psychotropic medication (mind altering drug) for a resident, facility should ensure that physician/prescriber has conducted a comprehensive assessment of resident and has documented in clinical record that psychopharmacological medication is necessary .It is the responsibility of attending healthcare practitioner to inform the resident and or resident representative of the initiation, reason for use and the risk associated with use of psychotropic medication per facility policy or applicable state regulation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47197 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 112 when; 1. A shared glucometer (a device which measures blood sugar using blood from the fingertip) was not cleaned and sanitized properly after use and before storage; 2. A clean residents' personal items delivery cart was found with a thick layer of dust on its tray; 3. Shared glucometers (a device used to measure blood sugar) were not cleaned and sanitized based on manufacturer instruction when used for Resident 109 and Resident 315. 4. The facility did not follow safe infection prevention practices when care provided to Resident 82 with tube feeding and medication administration, in a room marked as Enhanced Barrier Precaution (or EBP, staff to use gown and gloves as protection to prevent spread of bugs or infections) These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 92, Resident 109, and Resident 315 to germs, and may cause infection among residents, staff, and visitors. Findings: 1. During an observation on 11/4/24 at 11:44 a.m., Licensed Nurse (LN) 6 was observed checking a resident's blood sugar using a glucometer [EvenCare G3 blood glucose monitoring system] which was shared between residents. LN 6 used a lancet (a sharp piercing device) to pierce the resident's finger to get blood and then applied the blood to the test strip that was attached to the glucometer. After reading the result, LN 6 discarded the used lancet and test strip, wiped the shared glucometer with alcohol prep pad (pads used to clean the skin prior to bandaging, wiping off surfaces like desks, sinks and counters, and cleaning hands), and stored the glucometer in the medication cart. During a concurrent observation and interview on 11/4/24 at 11:48 a.m. with LN 6, LN 6 confirmed that she used an alcohol wipe to clean and sanitize the used glucometer before storing it in the medication cart. LN 6 stated staff should use the purple top wipes (Medline Micro-Kill Germicidal Wipes) when cleaning a glucometer after it was used for a resident. LN 6 also stated she did not have the germicidal wipes in the medication cart as the reason why she used the alcohol prep pad. LN 6 further stated it is not okay to use an alcohol prep pad. During an interview on 11/6/24 at 2:03 p.m. with the Infection Preventionist (IP), the IP stated, We [facility staff]don't have dedicated glucometers for each resident, we use shared glucometers .That's [cleaning a shared glucometer with alcohol wipes] a concern of transmission of blood borne pathogens [microorganisms that can cause disease and are present in human blood] .It [glucometer] should be disinfected properly before and after use . We [facility] utilize Medline's Micro-kill antimicrobial wipes- the purple tops which are indicated for the glucometers we use .No, most definitely not [okay to use alcohol wipes in cleaning and sanitizing used glucometers]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 3:46 p.m. with the Director of Nursing (DON), the DON stated that per the facility's policy and manufacturer's instructions, the purple top (Medline Micro-Kill Germicidal Wipes) is one of the approved wipes for the glucometers the facility utilizes. The DON further stated she would expect the staff to follow the facility's policy in cleaning the glucometers. A review of the facility's policy and procedures (P&P) titled, Glucometer Disinfection, dated 6/1/24, indicated, 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. A review of the manufacturer's instructions for EvenCare G3 blood glucose monitoring system titled, CLEANING AND DISINFECTING, undated, indicated, .The EVENCARE G3 Meter should be cleaned and disinfected between each patient .The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter: .Medline Micro-Kill .Germicidal .Wipes . Alcohol prep pad was not listed as an approved product for cleaning and disinfecting the glucometer. 2. During a concurrent observation and interview on 11/4/24 at 9:47 a.m., at Hallway 1, with Laundry Staff [LS], LS was observed delivering clean personal items to residents in hallway 1. Upon checking the clean residents' personal item delivery cart, the delivery cart's tray was found with a thick layer of dust. LS confirmed the observation. During a concurrent observation and interview on 11/4/24 at 9:52 a.m., at Hallway 1, with Central Supply [CS], CS confirmed that the clean residents' personal item delivery cart has thick layer of dust on its tray and stated, It's [clean residents' personal items delivery cart] supposed to be always clean. During an interview on 11/6/24 at 10:52 a.m. with the Laundry Supervisor (LSPV), the LSPV stated they only have one clean resident's personal item delivery cart in the facility and staff should clean it every day. The LSPV also stated he would expect staff to make sure residents' personal item delivery cart to be always clean to make sure that residents' personal items are also clean. The LSPV agreed that if the delivery cart has dust, it could get into the clean clothes and would have a potential for residents to be exposed to dust and germs. During an interview on 11/6/24 at 3:46 p.m. with the DON, the DON stated she would expect the clean residents' personal items delivery cart should not be dusty. The DON further stated if the delivery cart is dusty, the dust could transfer to the clean residents' clothes. A review of the facility's P&P titled, Infection Prevention and Control Program, dated 7/1/23, indicated, 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . A review of the facility's P&P titled, Handling Clean Linen, dated 3/1/23, indicated, It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection .4. Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil .such as: .b. Placing clean linen in a properly cleaned cart . 40903 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a medication administration observation, with Licensed Nurse 7 (LN 7), on 11/4/24, at 11:57 a.m., LN 7 with a gloved hand took the glucometer and supplies in Resident 315's room to measure the blood sugar. LN 7 poked Resident 315's right middle finger to get the blood and soaked the test strip (a plastic strip contains chemicals to help with blood sugar measurement) with blood to measure the blood sugar. LN 7 used one Sani-Cloth wipe (brand name for a wipe with chemicals to disinfect surfaces) quickly (less than 10 seconds) to clean the glucometer outer surface once out of the Resident 315's room. During the subsequent medication administration observation, with LN 7, on 11/4/24, at 12:03 p.m., LN 7 with a gloved hand used the same glucometer and took supplies into Resident 109's room to measure blood sugar. LN 7 placed the glucometer on Resident 109's bed-side table when he poked Resident 109's left finger to get blood. LN 7 then soaked the test strip with blood for the blood sugar measurement. LN 7 used one Sani-Cloth wipe to quickly (less than 10 seconds) clean the outer surface of glucometer. In an interview with LN 7 on 11/5/24, at 10:48 a.m., LN 7 stated she assumed using one wipe to clean the glucometer was adequate enough to sanitize. LN 7 stated the Sani-Wipe bottle indicated 2 minutes wet time (the time for surface of glucometer remained wet to kill possible bugs on the surface) and when the surface was dry, she placed the glucometer in the drawer. In an interview with the Infection Prevention nurse (IP), on 11/5/24, at 2:07 p.m., the IP stated the nursing staff were educated to clean and disinfect the shared glucometer in-between resident use. The IP stated it was a two-step process to use one wipe to clean and then a second wipe used to sanitize and keep the outer surface wet so you can see the wetness with eye for minimum of 2 minutes per Sani-Wipe instruction. In an interview with DON on 11/5/24, at 2:16 p.m., the DON stated the new staff received orientation and skill checks on how to use shared glucometers and how to clean and sanitize after each resident use to prevent the spread of infection. The DON stated the nursing staff should have followed the facility's policy to avoid cross contamination in-between use. Review of the facility's policy, titled Blood Glucose Monitoring, dated 1/1/23, the policy indicated The nurse will perform the blood sugar test utilizing the facilities glucometer as per manufacturer's instruction. The nurse will abide by infection control practices of cleaning and disinfection of glucometer as per manufacturer instruction and in accordance with facility's glucometer disinfection policy. The nurse is responsible for cleaning and disinfection of machine following the manufacturer's instructions. Review of EVENCARE G3 glucometer (brand name glucometer used in the facility) manufacturer instructions, dated 2016, the document indicated The EVENCARE G3 Meter should be cleaned and disinfected between each patient. The document further indicated there were two steps for cleaning and disinfecting the meter. Cleaning and disinfecting the meter was very important in the prevention of infectious disease. Cleaning also allowed for subsequent disinfection to ensure germs and disease-causing agents were destroyed on the meter as follow: a. To clean the meter, use a moist lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter until visibly clean. B. To disinfect the meter, wipe with one of the validated disinfecting wipes and allow to remain wet for the contact time (time needed for the disinfectant stay in touch with the outer surface of the glucometer to kill all the germs) listed on the wipe's directions for use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a medication administration observation, with LN 6, on 11/4/24, at 4:27 p.m., LN 6 crushed a medication called glycopyrrolate (drug used to reduce secretions in the mouth) to administer to Resident 82 through the feeding tube (a surgically inserted tube into the stomach.) LN 6 entered the room with gloved hand and no gown was put on. Resident 82's room was marked as Enhanced Barrier Precaution (or EBP) room, which required to put on gloves and protective gown to enter the room for tasks like medication administration through a feeding tube. LN 6 administered the medication using a syringe to push the medication inside the stomach via the feeding tube hub. In a concurrent observation and interview with LN 6 on 11/4/24, at 4:50 p.m., LN 6 acknowledged the room was marked as EBP which required use of a gown and gloves to care for a resident with tube feeding care. The gown supply was located behind the resident's room and not visible to the nurse. In an interview with Director of Nursing (DON), on 11/5/24, at 3:43 p.m., the DON stated the staff should follow the guidelines for the use of protective gowns and gloves when accessing the feeding tube for medication administration. Review of the facility's policy, titled Enhanced Barrier Precaution, dated 5/1/24, the policy indicated Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multi drug resistant organisms that employs targeted gown and glove use during high contact resident care activities . Make gown and gloves available immediately near or outside residence room . PPE (Personal Protective Equipment, items such as gloves, mask, or gown) for enhanced barrier precaution is only necessary when performing high contact care activities . High contact resident care activities include: . device care or use: . feeding tube.